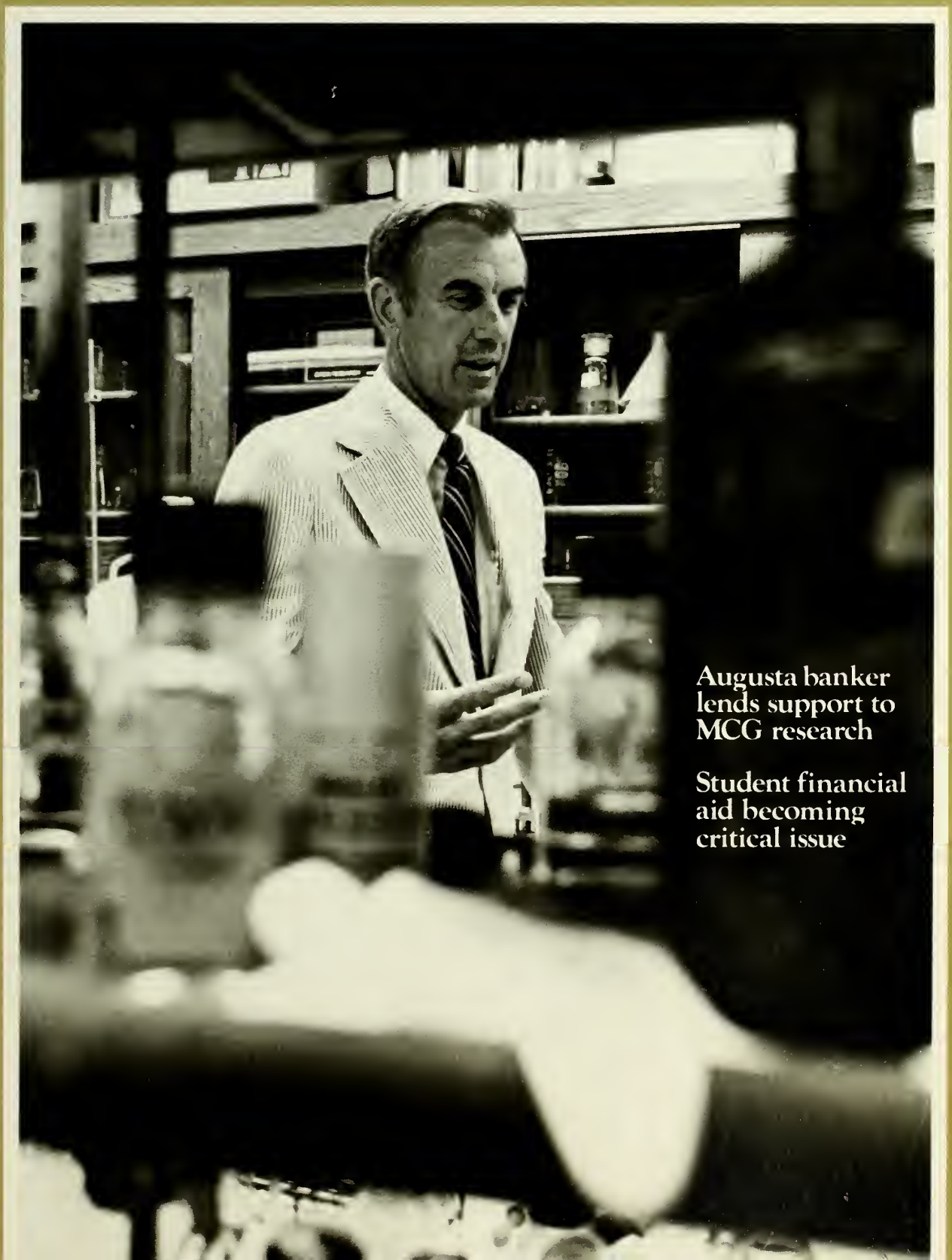
MCG Today

Medical College of Georgia, Summer 1981, Vol. 10, No. 2



Augusta banker lends support to MCG research

Student financial aid becoming critical issue

As Spring came with its traditional new growth, we too planted a new campaign to foster growth in research. Graeme M. Keith, one of the most capable and distinguished gentlemen available, has agreed to chair the steering committee for the $250,000 MCG Research Institute Campaign.

As I have often said, there is no substitute for good planning, hard work and dedicated leadership — leadership willing to use influence and personal commitment to the common goal of an uncommonly good cause. It is with great pleasure that I welcome Mr. Keith to our campaign effort. Today he is president of the oldest bank south of Washington, D.C., the Georgia Railroad Bank and Trust Company, in Augusta. He came here with an impressive background of hard work and leadership both in the banking field and in civic commitments.

We also have acquiesced to Gerry Achenbach's request to name another chairman for the President's Advisory Council, and have found another equally able leader in Charles Presley. He was given the reins of the PAC at our April meeting. Everyone recognizes the contributions Mr. Achenbach made in nurturing the PAC into a healthy, strong organization. We are fortunate that Mr. Presley has agreed to continue ensuring the invaluable service of the PAC.

Dr. Moretz presented a framed letter of appreciation, which summarized our gratitude for Mr. Achenbach's "seven years of dedicated service, his invaluable advice, his financial support, his desire to see medicine in the United States remain free, competitive and the best in the world and for his friendship and loyalty."

And, we have planted one more seed for future growth . . . our long-time friend, loyal associate and fellow professional, Alex H. Vaughn has moved into the position of Associate Director for Development. We are confident that he will bring strong leadership to our corporate and foundation development efforts. Our current plans are to introduce to you the new public relations officer in the Fall magazine.

We have had a rewarding Spring, one that promises gratifying future growth.

JCA

MCG Today

Medical College of Georgia, Summer, 1981, Vol. 10, No. 2, USPS867340

CONTENTS

Graeme Keith: One of the best heads up MCGRI campaign 5

Renal Research: It's come a long way and has a long way to go.....6

'Why does my child have to die?' 10

'A fine doctor and a hell of a fisherman' 12

Phillips' pace is a rapid step-by-step.....14

Student aid losses causing concern among MCG students.....16

Homecoming 1981 17

MCG Today (USPS) is published quarterly. It is sponsored by annual grants from the MCG Foundation, Inc., and is prepared by the Division of Institutional Relations, Medical College of Georgia, Augusta, Georgia. Second-class postage is paid at Augusta, Georgia.

MCG Today is furnished to alumni and friends of MCG without charge. Letters to the Editor are welcomed. Manuscripts should be accompanied by a stamped, self-addressed envelope. Classnote news items should include name, degree and year of graduation of alumnus. POSTMASTER: Send address changes to **MCG Today,** 1120 Fifteenth Street, EA-100, Augusta, Georgia 30912.

STAFF:

Executive Editor
James C. Austin

Managing Editor
Alex H. Vaughn

Editors
Julie Guillebeau
Mandy Roth

Design
Garon Hart

Editorial Staff:
Doug Vinson
John Donnelly
Cheryl Jackson

MCG Foundation, Inc.
Board of Directors

Officers

President
J. Harold Harrison, M.D.

First Vice President
David A. Wells, M.D.

Second Vice President
Curtis Hames, M.D.

Secretary-Treasurer
Robert G. Ellison, M.D.

Executive Director
Mr. James C. Austin

Other Members of Board of Directors

Mr. Gerry H. Achenbach
Chairman of the Board
Piggly Wiggly Southern, Inc.
Vidalia, Georgia

Mr. Arthur C. Baxter
Executive Vice-President
The First National Bank of Atlanta
Atlanta, Georgia

Donald Branyon, Jr., M.D.
Athens, Georgia

Mr. James A. Crockett
Vice President and Treasurer (Retired)
Piggly Wiggly Southern, Inc.
Vidalia, Georgia

Harry Dawson, Sr., M.D.
Shannon, Georgia

Harold S. Engler, M.D.
Augusta, Georgia

John C. Hagler, III
Chairman of the Board
G.I.W. Industries, Inc.
Augusta, Georgia

Chenault W. Hailey, M.D.
Atlanta, Georgia

H. Calvin Jackson, M.D.
Manchester, Georgia

Floyd C. Jarrell, Jr., M.D.
Columbus, Georgia

LaMar S. McGinnis, Jr., M.D.
Atlanta, Georgia

Harvey M. Newman, III, M.D.
Gainesville, Georgia

Mr. Charles Presley
Chairman of the Board
Georgia Railroad Bank & Trust Company
Augusta, Georgia

John H. Robinson, III, M.D.
Americus, Georgia

William Shirley, M.D.
Macon, Georgia

Irving Victor, M.D.
Savannah, Georgia

Ex Officio Members

William H. Moretz, M.D.
President, Medical College of Georgia

Lois T. Ellison, M.D.
Provost, Medical College of Georgia

Mr. James A. Blissit
Vice President & Treasurer
Medical College of Georgia

Raymond C. Bard, Ph.D.
Dean, School of Allied Health Sciences
Medical College of Georgia

Fairfield Goodale, M.D.
Dean, School of Medicine
Medical College of Georgia

Judson C. Hickey, D.D.S.
Dean, School of Dentistry
Medical College of Georgia

Sam Singal, Ph.D.
Dean, School of Graduate Studies
Medical College of Georgia

Mary Conway, Ph.D.
Dean, School of Nursing
Medical College of Georgia

MCG Alumni Presidents and MCGF Directors

Geraldine Rinker, M.S., M.B.A.
President
School of Allied Health Sciences Alumni Assn.

David Wells, M.D.
President, School of Medicine Alumni Assn.

Suzanne P. Bohler, B.S.N.
President, School of Nursing Alumni Assn.

Norris O'Dell, D.M.D., Ph.D.
President, School of Dentistry Alumni Assn.

David A. Welter, Ph.D.
President
School of Graduate Studies Alumni Assn.

CAMPUS NEWS

Mansberger, Smith tapped for national honors

Two faculty members at the Medical College of Georgia have recieved national appointments.

Dr. Arlie Mansberger, professor and chairman of the department of surgery since 1973, will assume duties as vice chairman of the American Board of Surgery effective July, 1981. Mansberger is Governor of the American College of Surgeons and a member of several other national committees. He has authored more than 100 articles and publications.

Dr. J. Graham Smith, professor and chairman of the department of dermatology was elected president of the American Board of Dermatology. He has been a member of this organization for seven years. He also serves on several other national committees and the editorial boards of various journals including the *Journal of the American Medical Association.* He has been at MCG since 1973.

Smith has also been selected to receive the Distinguished Alumni Award of Duke University Medical Center. The award will be presented at a banquet in November.

Blood bank accredited

Talmadge Memorial Hospital Blood Bank has been awarded a two year accreditation by the American Association of Blood Banks (AABB), according to Dr. M. M. Fatteh, director of the Talmadge Blood Bank.

Accreditation follows an on-site inspection by specially trained AABB representatives and establishes that the level of medical, technical and administrative performance within the facility meets or exceeds AABB standards.

Hutchinson named to PAC

W. R. Hutchinson of Thomson has been named to the PAC, announces Dr. William H. Moretz.

Hutchinson is president and chief executive officer of Brigadier Industries Corp.

Additionally he is director of the Thomson Chamber of Commerce and chairman of the board of several local businesses.

As an outstanding civic leader he is one who is deeply concerned and interested in his community and certainly will be an asset to the PAC, commented Dr. Moretz.

Stoddard named to head international organization

Dr. Leland Stoddard, professor of pathology, has been installed as president of the United States-Canadian Division of the International Academy of Pathology.

The professor has served as secretary-treasurer of the US-Canadian Division and as treasurer of the International Academy.

Stoddard is a graduate of Johns Hopkins University School of Medicine and has been a member of MCG's faculty since 1954.

Boe is rad therapy center director

Dr. Gerald P. Boe has been named administrative director of the Georgia Radiation Therapy Center. He assumed his position Jan. 9.

Boe has served as administrative chief, department of pathology, Dwight David Eisenhower Medical Center, Ft. Gordon. He retired from active military duty at the rank of lieutenant colonel, following 21 years in the military.

Chinese physician visits nutrition institute

Dr. Chen Rendun, research associate professor of the Military Hygiene Institute, Academy of Military Sciences, Tianjin, People's Republic of China has been visiting the Georgia Institute of Human Nutrition.

Dr. Chen is an MD nutritionist whose interests are in vitamin A

and energy nutrition. He has also published in the areas of cancer and the effects of irradiation of food.

Dr. Chen is spending a year in the United States for advanced training as a special senior fellow of the United Nations University World Hunger Program. He will be spending six months as visiting professor with the Georgia Institute of Human Nutrition (GIHN) at MCG. His visit is sponsored by the GIHN and the MCG School of Medicine.

Sub-specialty program accepts trainees

The Reproductive Endocrine Program at MCG has been approved by the American Board of Obstetrics and Gynecology to accept three trainees for fellowships.

The program falls under the auspices of the departments of obstetrics and gynecology and endocrinology.

Those accepted in the two-year fellowship program will study menstrual disorders, genetics of reproduction, improved surgical techniques and other problems related to reproduction and infertility, says Dr. Paul G. McDonough, professor and chief of reproductive endocrinology and genetics. Many of the areas receiving public attention today, such as in vitro fertilization, will be investigated by the fellows.

Duke medical school is the only other Eastern seaboard program with institutional approval for an equal number of trainees in this subspecialty, McDonough says.

Huisman named editor

Dr. Titus H. J. Huisman, chairman of cell and molecular biology at MCG has edited two special combined issues of the international journal "Hemoglobin."

The two issues concern the proceedings of the recent U.S.-Japan Cooperative Science Program on Abnormalities in Hemoglobin and Red Cell Enzymes.

Hinman meeting features MCG dentists

Several MCG dentists participated in the 69th annual Thomas P. Hinman meeting.

Dr. Eugene Williamson, associate professor of orthodontics, was selected as one of the featured clinicians and gave programs during the four day meeting.

Symposiums also were given by Dr. Kenneth Anusavice, assistant professor of restorative dentistry, and Dr. William Wege, professor of oral medicine and associate professor of radiology.

Dr. Edwin Joy, chairman of oral surgery presented a workshop for dental assistants, dental hygienists and business office staff.

Dr. Hinman, in whose honor the meeting is held, was a charter member of the American College of Dentists and ex-president of the Georgia State Dental Society. He established the meeting as a means of exchanging ideas and scholarly papers among dentists. It has grown to be one of the largest dental meetings in America. Dr. Hinman died in 1931.

Dr. Loree Florence, '26, MCG's first female graduate in the School of Medicine, talks with (L-R) Dr. William Strong, pediatrics; Dr. Paul Webster, medicine and (far right) Dr. Lois Ellison, provost. Dr. Florence's portrait was presented to the library and accepted by Dr. Ellison who praised Dr. Florence for her character and accomplishments. Dr. Florence retired in 1971 after practicing pediatrics in her hometown of Athens for almost 30 years.

Rao investigates Rashkind Occluder

Dr. Syamasundar Rao, professor of pediatrics and associate director of pediatric cardiology at MCG, has been chosen as an investigator for the Rashkind Occluder, a catheter closure device used to correct certain types of congenital heart defects in children without surgery. MCG is one of seven centers for this investigation.

As one of the investigators chosen to participate in evaluating the Rashkind Occluder, Rao spent a month working with Dr. Wiliam Rashkind last year.

According to Rao, there are two main heart problems in children, the atrial septal defects and patent ductus arteriosus. Both of these problems can be corrected with open heart surgery procedures, he says, but the cost is high ($4,000-$5,000) and the length of stay in the hospital ranges from seven to 10 days.

On the other hand, the Rashkind Occluder, an umbrella-like device, is not open heart surgery. "The occluder, in a 'closed' position, is carried to the atrial defect by running a catheter in a vein and up to the defect," Rao says. "When the occluder is past the defect, it is 'opened' and drawn back until it covers the defect. There are hooks on the back side of the occluder that hold it to the surrounding tissue and the catheter is withdrawn. The patient can go home three days after the procedure, the cost is less and the chest doesn't have to be opened."

The procedure has not been approved for use on humans. The pediatrician explains that within six months all necessary presentations to proper committees should have been made and the procedure can begin to be used on humans. One firm already has plans to produce the occluder.

School of Nursing alumni and faculty honored Leilee P. Ault May 15 with the Annual Phoebe Kandel Rohrer Founders Award. President of the School of Nursing Alumni Association Suzanne Bohler, (L) makes the award during ceremonies at the Officers Club, Fort Gordon.

Graeme Keith: one of the best heads up MCGRI campaign

by Doug Vinson

When he was graduated with a degree in business administration from Davidson College in 1954 he wasn't sure what he wanted to do, but he knew he wanted to work in the world of finance.

While serving as a 1st lieutenant in the Army he met several individuals who offered him banking jobs. When he completed his military duty, the enterprising young man decided to work for the Union National Bank of Charlotte, N.C.

When he began working with the Union National Bank (now the First Union National Bank) in 1956 it had assets of $70 million. When he left the bank as regional executive vice president in 1973 the bank's assets totaled $1 billion, 300 million with offices in 81 communities throughout the state. Under his direction the bank made 27 mergers and major acquisitions.

Today Graeme Keith is president of the oldest bank south of Washington, D.C. and the largest bank in Georgia outside of Atlanta — The Georgia Railroad Bank.

With a warm, engaging manner Keith speaks with quiet confidence and from all appearances seems to be a banker's banker.

On a 'typical' day Keith arrives at 7:30 am. After meetings, planning sessions and more meetings he heads home around 6:30 or 7 pm.

Keith's accomplishments are not confined solely to the banking realm. He has been past president of the Augusta Chamber of Commerce, chairman of the United Way campaign, director of Junior Achievement and director of Kiwanis.

He has served on the executive board of the Georgia-Carolina Council for the Boy Scouts and the board of directors for the Augusta Symphony. Currently he is a member of the Geor-

gia Business Community for the Arts, the board of trustees for the Augusta College Foundation and the Augusta Preparatory School. Keith was born in Greenwood, S.C.

His achievements in fund raising are as noteworthy as his civic endeavors. He was general chairman for a $6 million campaign for Queens and Davidson Colleges several years ago. He also served on the steering committee for the Billy Graham Center at Wheaton College. Keith has been a friend of the evangelist since 1956.

Keith was recently named to the President's Advisory Council at MCG and he will be chairing the steering committee for the $250,000 fund raising effort for the Research Institute.

Keith plans to work closely with Dr. William Davis, director of the Research Institute, James C. Austin, medical college development officer, along with other members of the PAC in selecting people and corporations interested in supporting research.

"Although we haven't formalized any plans at this point we will not be involved with any mass campaigning. We will focus on a limited group of people.

"We really want to promote the importance of research. The money we raise for the Institute will provide a foundation to enhance future research at MCG, which in turn will improve health care for all of us.

"If people stop and think about the many tangible results of research that affect our daily lives you don't have to try to 'sell' them on the importance of it, they realize it.

"MCG has some excellent researchers, but in order to facilitate their work and attract other quality researchers, additional funding is needed," says Keith.

Keith is ruling elder at Reid Presbyterian Church where he teaches in the Sunday School program.

Frequent business trips take him away from home, but Keith enjoys spending time with his three sons and his wife, Gloria.

An avid sportsman, he was captain of the golf and basketball teams at Davidson and plays golf and tennis regularly.

How does a man who is deeply involved in his work, his community and his family keep all the balls bouncing?

Keith's answer is, "My outlook on life was greatly influenced by the close-knit Christian family I grew up in. My parents instilled in me a desire to use God-given talents in a compassionate and constructive way. They taught me the importance of organization and self-discipline."

Renal Research: It's come a long way — and has a long way to go

by John Donnelly

Currently there are over 1,000 Georgians on hemodialysis because their kidneys have failed. Kidneys clean and filter the blood, ridding our bodies of waste and toxins.

There are many diseases, including high blood pressure, which can reduce the ability of the kidneys to perform this routine cleansing which then must be done by machine in a process called dialysis. Without this assistance, these people would die.

Fortunately, there are several methods by which they can continue to lead productive lives while researchers delve into ways to give them even greater independence from their life-saving dialysis machines.

At the Medical College of Georgia, the End Stage Renal Disease Program dialyzes 43 patients "in center" and oversees the home dialysis of an additional 15 patients. To accommodate the 43 patients who receive their chronic treatment "in center" at the hospital and 5 to 15 other patients who are receiving treatment for "acute" disorders, MCG uses 15 dialysis machines. Citizens may be referred from all over the state to begin their treatment at the medical college and then be sent to receive continuing treatment at a dialysis center nearer their home. Still, patients are seen at the medical college from as far away as 60 to 75 miles on a thrice weekly basis.

Patients with chronic kidney, or renal, disease will at some point in their treatment be referred to a nephrologist, a physician specializing in kidney disease. The nephrologist will monitor patients and put them on dialysis when their condition reaches what is termed end-stage. Blood tests help the nephrologist determine when the patient reaches this stage.

At the time when it is determined the patient needs to be placed on dialysis, an operation called a vascular access is performed. At the MCG, these operations are done by Dr. Arthur Humphries, professor of surgery and director of the Kidney Transplant Program. Dr. Humphries is internationally known for his pioneering work in the field of successfully preserving kidneys for transplantation and is currently involved in the surgical aspects of both dialysis and kidneys transplantation.

Dr. Humphries (left) and Dr. Robert Nesbit employ dog surgery in research to find better ways of insuring success in kidney transplants. Billy Hamilton provides assistance.

Access operations can be done in three ways. The first is an arteriovenous, or AV, shunt. The surgeon inserts one catheter into an artery and the other into a vein of either an arm or leg. The catheters project through the skin and are connected together when the patient is not on the dialysis machine. When the patient is on the machine, the two catheters are attached to the dialysis machine which takes over the kidney's function, filtering out the impurities from the blood.

The AV shunt is usually a temporary device, lasting only three to twelve months before it has to be replaced. One reason for replacement is that the catheters can become obstructed by the blood clotting in them. Also, because they are external, they are subject to infection. For many years, however, the AV shunt was the only method available to patients in need of dialysis.

The second type of access surgery is the AV fistula procedure. In this, an incision is made, again in the arm or leg, and an opening is surgically created between a vein and an artery. According to Dr. Humphries, within several weeks time, the vein becomes greatly enlarged, so that technicians can puncture them with needles through which blood can flow to and from the dialysis machine. "The main advantage of this procedure is that it does not leave any external hardware attached to the patient. For a patient with a good AV fistula, the vein is easy to find so the nurse doesn't have to probe for a vein to use," he states.

The third method of access surgery involves a procedure similar to the fistula technique. An artificial vein, either a bovine (cattle) artery or a synthetic material (Gore-Tex), is interposed between an artery and a vein in the arm or leg. Such grafts are needed for many patients whose own veins are inadequate.

The process of dialysis is one which involves a great deal of time for those who must rely on the machines to do the work of their kidneys. Dr. Humphries says a patient usually has to be

on a dialysis machine three to six hours a day, two to three times a week. "The actual amount of time depends on the general condition of the patient. The ones who don't follow their diets and food restrictions have to be dialyzed more times and for a longer period of time than those who stay within their diets," the surgeon relates.

The restrictions placed on a person on dialysis mainly have to do with limiting the intake of protein. "We also have many patients who are on sodium and potassium restrictions. An intake of foods high in these substances changes the blood chemistry and means a person has to spend more time on the dialysis machine removing the impurities," he says.

In addition to food restrictions, a person on dialysis also is restricted to consuming only about a liter of fluids a day. This means that for a 24 hour period, a person on dialysis can consume only a little more liquid than is found in three 12 ounce drink cans.

The cost of maintaining a patient on dialysis depends on whether the person is being seen "in center" or dialyzes himself at home. The cost ranges from $10,000 to $50,000 per year per patient. Essentially all patients have the total cost of dialysis covered by Medicare, Dr. James B. Hudson chief of nephrology relates. "Since it is less expensive to have the patient dialyze himself at home, we are constantly teaching patients how they can perform this task," he says. In addition, Medicare covers the cost of having a kidney transplant.

One new advance in the area of dialysis which is making life easier for some patients is the Continuous Ambulatory Peritoneal Dialysis (CAPD) method in which a relatively permanent catheter, called a Tenckoff catheter, is implanted in the peritoneal cavity. At specified intervals during the day, a solution bag is hooked up to the catheter and run into the abdomen. The bag is clamped off for a predetermined period of time and then drained. This process is called an exchange and it is necessary to do four to six exchanges a day. Dr. Humphries says this process can be done at home and some people can do it at work. "It makes for a much more independent patient," he adds. As with the AV shunt, however, the catheter is partially external and good personal hygiene is imperative to prevent infection, Dr. Humphries says.

Despite the advances in making renal dialysis machines more portable and easier for the patient to manage, the machine is still the master the patient must serve in order to stay alive. As medical technology has advanced surgeons have become able to transplant kidneys, doing away with the necessity of dialysis for those with the good fortune to find a suitable kidney transplant.

If the end stage renal disease patient chooses to try a kidney transplant he first must have a suitable kidney available which can be used to function as his own. Since 70 percent of all kidney transplants are performed with kidneys from deceased donors, a method of keeping kidneys alive has been developed. It is in this area of kidney preservation that Dr. Humphries gained international recognition.

". . . it is now possible to keep a kidney functioning for three days . . . and still be able to transplant it into another patient."

When a kidney is harvested from a cadaver donor, it begins to deteriorate. To slow this decay, it must be kept cool and/or supplied with oxygen by perfusion until it reaches a recipient. Dr. Humphries was one of the first in the world to devise a method for pumping a cool plasma solution through the kidney, just as blood would flow, to minimize decomposition. Using dogs, he was the first to keep a kidney alive for 24 hours and then transplant it back into the dog and have it function and keep the dog alive. He also was the first to preserve and re-implant kidneys after two, three, four and five days.

Due in great part to his research, it is now possible to keep a kidney functioning for three days on a pumping machine, called a kidney perfusion machine, and still be able to transplant it into another patient. Techniques have also been refined to the point a kidney can be cooled with a special solution and kept on ice without a perfusion machine for 24 hours and still be transplanted.

The need for preservation is not as great in the other 30 percent of the transplant cases where the donor kidney comes from a close family member. These are called living related transplants — the donor is a parent, sibling, child, aunt, uncle, or cousin of the recipient. In these cases, both the donor and the recipient usually are in the operating room at the same time and the amount of time before the kidney can be transplanted is minimal, Dr. Humphries says.

According to the surgeon, the transplant operation takes between four and six hours. There are a great many people involved in the operation, bringing in specialists as needed to assist in various phases of the procedure.

In addition to the surgeons who perform the operation, nurses, physicians assistants, medical technologists, who do the tissue typing for blood and antigen matches, and perfusionists who keep the kidney functioning until time for transplantation are on the Transplant Team.

The actual operation begins with a diagonal incision starting below the rib cage and extending to the body midline. In the majority of cases, the native kidneys which are no longer functioning are left in place. "If the native kidneys are to be removed," Dr. Humphries points out, "this is done several months before the actual transplant."

Cadaver donor kidneys, when removed, are divided, with each kidney going to a different recipient. Dr. Humphries will, when taking the kidneys out, leave the artery and vein, as well as the ureter, attached to the kidney.

The kidney is then transplanted into the lower abdominal area, called the inguinal area, and are not placed

where the native kidneys rest. Dr. Humphries says the reasons for this are that the location is easier to get to surgically and there is a good source for a blood supply for the kidney in the inguinal area. The artery attached to the donor kidney is sewn into the hypogastric artery and the vein is sewn to the external iliac vein. According to the surgeon, this portion of the procedure takes about 45 minutes.

An additional 30 minutes is taken by the assisting urologist to sew the ureter into the recipient's bladder. This is done by cutting a small hole in the bladder and sewing the section of ureter from the donor kidney to it.

The first indication as to whether or not the kidney has been accepted by the recipient can come almost immediately, Dr. Humphries says. "The patient may hyper-acutely reject the kidney on the operating table. When this happens, the kidney will turn black instead of 'pinking up.' "

If the recipient rejects the kidney at a later date, the physician can diagnose this because the patient may become ill, his blood chemistries may change, and the kidney may stop functioning. When it has been determined there has been a complete rejection of the kidney, another operation may be necessary to remove the transplanted kidney. "The patient then goes back on dialysis until another kidney can be found to match their blood type and antigens," Dr. Humphries relates.

Because of the chance of rejection of the kidney, the hospital stay for patients having kidney transplants ranges from two to twelve weeks. "The reason for the wide variation in the amount of time spent in the hospital mainly has to do with whether the kidney is from a living related donor or a cadaver donor," Dr. Humphries explains. "With a living related transplant smaller doses of drugs have to be used so the patient does not have to be monitored as long."

During the hospital stay, the physician watches for problems with the blood. "The two main problems we encounter are decreased white blood cell count and decreased platelet count," Dr. Humphries says. "The danger in decreased white blood count is that the patient is left more open to infections and the danger of decreased platelet count is that if it gets too low, a bleeding tendency might develop."

In order to keep the patient's condition stable following the transplant, several drugs are currently in use. The two main ones being used are Prednisone and Imuran, also known as azathiopine. "These drugs are immunosuppressants that all patients are given following the transplant. They also receive doses of vitamins and antacids, and may be given diuretics or other medications for high blood pressure," Dr. Humphries relates. The patient must keep taking the immunosuppressants the rest of his life, although the Prednisone will be tapered down to only a very small dose, the surgeon says.

As there is a difference in the length of stay in the hospital for transplant patients according to whether or not they are recipients of cadaver or living related kidneys, so the chances of a successful transplant vary. "There is a 75 to 95 percent success rate using living related donor kidneys," Dr. Humphries states. "The figure for successful cadaveric transplants is between 50 and 60 percent."

To gather the data necessary to assure even the 50 to 60 percent success rate for the transplantation of cadaveric kidneys requires a very complex system. The first part is the work-up of the prospective recipient.

Blood work comprises a large part of the work-up. The transplant team needs to know the patient's blood type, Rh factor, blood count, electrolytes and other blood chemistries. Blood tests are also done to determine "tissue types." These will be used as the final test for compatibility between donor and recipient. Blood tests for syphillis and viral infections are done. Determination of the patient's cytotoxic antibodies (against lymphocyte antigens of potential donors) is another important test. The more antibodies a patient has, the more difficult the task of matching that patient with a kidney. Blacks are also tested for sickle cell disease.

Besides the blood work, prospective kidney recipients are given an EKG, a chest x-ray, an abdominal x-ray, a urine culture is taken and a urinalysis is done. A urological check-up including a voiding cystourethrogram is performed. A dental examination is done. Dr. Humphries explains that before the operation can be performed, the patient must be as free of infection as possible, which includes good oral health. The patient also undergoes a pulmonary function study.

A patient history is taken and can prove to be one of the most beneficial portions of the work-up to the potential kidney recipient. "In taking a patient's history it may be determined that there are relatives who are potential donors. When we find this to be the case, then we do much the same type of work-up on the relative."

If it is decided the relative's kidney can be used — a person can function with just one of their two kidneys — then a urological work-up is done as is an arteriogram, a special x-ray of the kidneys. The arteriogram allows the surgeon to check the blood supply to the kidneys and determine which of the kidneys he wants to use in the transplant. "We always look for the kidney which has a single artery," Dr. Humphries relates, "it is the easiest to transplant."

If a living related donor kidney is to be used, the surgery is set up and the operation on the donor and recipient are performed at the same time. If there are no relatives who can donate, the next step is to feed information about the patient into the South-Eastern Organ Procurement Foundation (SEOPF) computer. There are 41 health centers in the eastern third of the nation excluding New York, Pennsylvania and New England which belong to SEOPF.

As a member of this network, MCG feeds information about its patients needing kidneys into the SEOPF computer. The computer also includes information from patients in the United Network for Organ Sharing, which operates in most of the rest of the country. Thus, by using the computer, kidney procurement personnel can find the patients whose tissue types and antigens most closely match the cadaveric donor kidneys they have

procured.

Mary Anne House, RN, kidney procurement coordinator at the MCG, says when she has a donor kidney the information the computer prints out on the potential recipients whose antigens match the donor antigens include: the blood type, the antigens, the number of antibodies, where the patient is, and the phone number of the patient's center. "The print-out starts off by giving all perfect matches in the country. A perfect match is one which has all four antigens alike as well as matching blood type. The next category is SEOPF patients by antigen matches, from three matches to one. The final category is antigen matches from three to one for the rest of the country."

House says besides looking for a perfect match in antigens, when SEOPF centers have a patient with antibodies to over 50 percent of the population they send around a sample of the patient's serum to the other centers. "If a donor kidney is a good match with several potential recipients, it is offered to the patient with the most antibodies (as long as the antibodies don't react against that kidney), because that patient will have the hardest time finding a kidney," she states.

Kidneys from cadaveric donors are obtained in two ways. In the first, a person has signed a kidney donation card which states when he dies his kidneys are to be removed and donated to patients currently on dialysis. The right of a person to sign a donor card was assured in Georgia by the 1969 passage of the Uniform Anatomical Gift Act. Since that time, the law has been passed in all 50 states. House adds, however, the donor card is only a statement of intent, "the signature of the next of kin is necessary when the donor dies." This law also gives the family the right to donate the organs of the deceased.

The procurement coordinator, when notified by an area hospital of a potential donor, may approach the family of a terminal patient to ask for their consent to donate organs, House says. "As soon as we can, we begin the process of tissue typing. This usually takes about five hours and the kidneys have usually been removed by the time the typing is done. Sometimes, we can pre-type a donor before death ensues but this opportunity does not happen often," she states.

Jim Harrington, (left) kidney preservationist with the New England organ bank, receives a kidney flown to Boston by MCG kidney procurement personnel Mary Anne House and Randy Hutchins. The kidney was finally placed in a recipient in Maine.

Once the donor has been typed, House consults the SEOPF computer to find the best matches for the kidneys. "When I find the best matches, I start calling the centers until I come up with recipients. There may be some very good match-ups that for one reason or another cannot have the transplant performed at that time, so I can end up spending a good deal of time of the phone."

When the kidneys have been placed, they are shipped to the centers where their recipients are waiting. The kidneys are already divided and in a sterile bag in a box of ice or on the perfusion machine. House or another procurement staff member goes with the kidney to its destination. The most common form of transportation is by aircraft, either commercial or chartered. Once at the destination, House will turn the kidney over to the procurement staff at the recipient's center and return to the Medical College.

The science of helping people with end stage renal disease has come a long way in the past 20 years, thanks in measure to the research conducted by Dr. Humphries. Besides doing access and transplant surgery, Dr. Humphries continues to be involved in research, now trying to find techniques that will reduce the chance of rejection of the kidney following transplantation.

Dr. Humphries is working on a procedure whereby he hooks the thoracic duct to the esophagus. "The thoracic duct drains the lymphocytes from the body," he explains, "and if we can get the lymphocytes to drain directly into the stomach where they are destroyed, then we will have removed a great potential for the rejection of the donated kidney." The lymphocytes play an important role in the rejection of the donated kidney.

Other benefits from perfecting this procedure include possibility of a shorter hospital stay for transplanted patients since the chance of infection would be lessened and, the surgeon says, the procedure could aid some patients who are now having a hard time being matched.

Continued research into perfecting the kidney transplant procedure is just one way MCG is fulfilling its responsibility to the citizens of the state. The more than 1,000 Georgians with the end stage renal disease look to the Medical College for dialysis, for the supervision and teaching they need to learn home dialysis and, hopefully, for the time a match can be found and they can receive a cadaver kidney that will function.

'Why does my child have to die?'

By Jenny Lou Jones

"Why me?" is a common rebuttal for any parents whose child has a terminal illness, says Sandy Hobbs, assistant professor of maternal child nursing at MCG. She says parents go through a series of stages before they realize the prognosis is true. The first stage most parents go through is shock — they can't believe it. After the shock stage is denial where they believe the diagnosis is wrong. They'll totally deny it until the child's failing health becomes apparent.

The next stage is usually anger. The parents are angry at everybody — at themselves, with each other, at the medical team, even with God. Then comes the stage of bargaining. They will bargain particularly with God and promise anything — "If you heal my child, I promise to never drink; I promise to never think bad thoughts."

Later most parents get to a point of acceptance and this is a two-fold step. Very often they will be able to accept that their child has a terminal illness but they can't accept that with their child it's going to be fatal. Then eventually they'll get to the stage where they can also accept the prognosis.

These are stages many parents go through, although they don't all go through them in the same way and may even skip some steps. Children go through some of the same steps, however, it depends upon their developmental level.

"Children under six months probably don't comprehend anything that's going on unless it's painful," says Hobbs. "Toddlers aren't able to understand the finiteness of death and what they respond to is fear of pain, fear of restriction, fear of separation."

Hobbs says that it's the same with preschoolers. It's not until around the age of nine or 10 do children begin an adult-like concept of death, comprehending the irreversibility and finiteness of death.

Many parents, says Hobbs, make the mistake of saying that Grandma died and went to sleep. So often children will then relate sleep to death and they will be afraid to sleep at night. School age children often think in terms of monsters and the superworld and they often will fantasize death as a big monster.

It's difficult to talk about death to a child, says Hobbs, especially if that child is yours and he's going to die. Generally, it's recommended to take a very honest approach, but first the parents need to know where the child is developmentally — is he to the point where he understands that death is inevitable. It's helpful to tell the sick child about his condition — the disease, the symptoms and the side effects. This lets the child know what to expect.

"One thing that so often happens and is very difficult to watch," says Hobbs, "is when the family chooses not to tell the child." Children sense that something is seriously wrong whether they're told or not. These children will get into game playing if the parents aren't honest with them. The child knows something is seriously wrong regardless of the facade that's being portrayed. A child often will begin to play the game to protect his parents because he realizes that they can't talk about it, so the child will pretend he doesn't know.

"It's a very lonely position for a

child to be in," says Hobbs. She adds that children deserve to hear that their parents and the people that care for them are sad that this is going on with them and their life has made a difference and they're valued people. "They want to know that they are not going to be forgotten."

The pressure of taking care of a sick child is not easy even when both parents give 100 percent. The situation tends to make one or both parents "edgy" around each other or their children.

In this day of women's lib, and with more and more women seeking employment outside the home, the mother's lifestyle probably suffers the greatest change.

During the course of the child's illness, the mother's roles change so that the emphasis is on being primarily mother. "Hopefully, not solely mother," says Hobbs, "because the marital relationship is so important and suffers so much during this."

Divorce rate among parents of terminally ill children is much higher than that of the normal population. One reason, says Hobbs, is that parents need someone to blame. "Communication often breaks down. Often this is because the mother is the one who must, or else chooses to, assume the primary caretaking role for the child and is not available and accessible for the husband and other children. Her life suddenly focuses on this one child," says Hobbs. Communication is allowed to disintegrate to a great degree and parents just stop talking. Too often they don't support each other emotionally. Fathers will worry about the hospital bills. This especially causes a strain if the mother has had to quit her job or take a leave of absence. This puts more and more pressure on the father to be the sole bread winner and get out and make enough money to cover the expenses.

Hobbs says fathers have often said that they can forget a little, while it's never completely out of their mind. They can throw themselves into their work when it's necessary and they aren't living every minute with this like many of the mothers.

Either during the course of the child's illness or after death, 50 percent of these families have at least one person who's going to need some professional counseling, says Hobbs. She says most parents, with few exceptions, will picture what his death will be like. They will agonize over it a great deal. Once death has occurred, many times there is some relief, even though there's also sadness and depression.

Most families often will also need to develop in their own minds a history of what occurred, says Hobbs. "They need to get it straight in their mind and have all the questions answered. It's especially helpful if they know that they did all they could do and everyone else did too at the end to make the child comfortable and the child was indeed not alone and not allowed to suffer."

A hug from heaven

By Jenny Lou Jones

God . . . can I talk to You about something?

Sure. Climb up in My arms

Where are Your arms, God?

Look around, I am a part of everything and everything is a part of Me. Crawl up in one of My trees and let the limbs be My arms.

Thanks, God. You always make me feel so warm.

What do you want to talk about?

Well, God, there's something I don't understand and it makes me sad. I was playing with my friend Joey yesterday. We played with my firetruck and I got to pet his dog. Did you know that his dog has one black eye and one white eye? Anyway, when I went to his house today and asked if he could come out, his mother said no and started crying. Then his father came out and said that Joey can't play today because he went on a little trip. When I asked if Joey could play tomorrow they slammed the door. Why won't they let Joey play with me? Did I do something to him?

No, R.B., You weren't bad to Joey. You see, Joey was hit by a car yesterday and died in the hospital last night.

Why did his dad say he went on a trip?

Parents often don't know how to say that someone they loved has died.

God, was Joey bad? Is that why he got killed?

R.B., people, little babies to old grandparents, die. It doesn't mean they did anything bad — it's a way of life.

Huh?

Well, it's like the flowers. People plant seeds to make flowers come up. They water and fertilize and carefully take care of their seeds until beautiful flowers appear. The flowers bloom in the springtime and it makes everyone happy. They dance in the wind; they stretch toward the sun; they bow toward the earth. They live a very happy life. Then when winter comes the dancing slows; the stretching stops and soon they bow very low to the ground and die. Then I swoop them up with my wind and take them home to heaven. There's nothing bad or wrong with it — it just happens with the seasons. So, you knew Joey in the springtime of his life, playing with trucks; running with kites; throwing rocks in the pond. But now winter has come for Joey and he died.

God, who will take care of him now?

I will R.B. He can climb up in My arms and I will take care of him.

You mean sit in a tree and the branches will hold him?

No, R.B., since he's in heaven, he can climb up in My real arms and I will hold him.

Will you give him a hug for me?

Sure, Now hold on tight because here comes a gust of wind.

Does that mean you're swooping Joey up to heaven?

Yes, and it also blows the branches around you tighter — that's a hug from Joey.

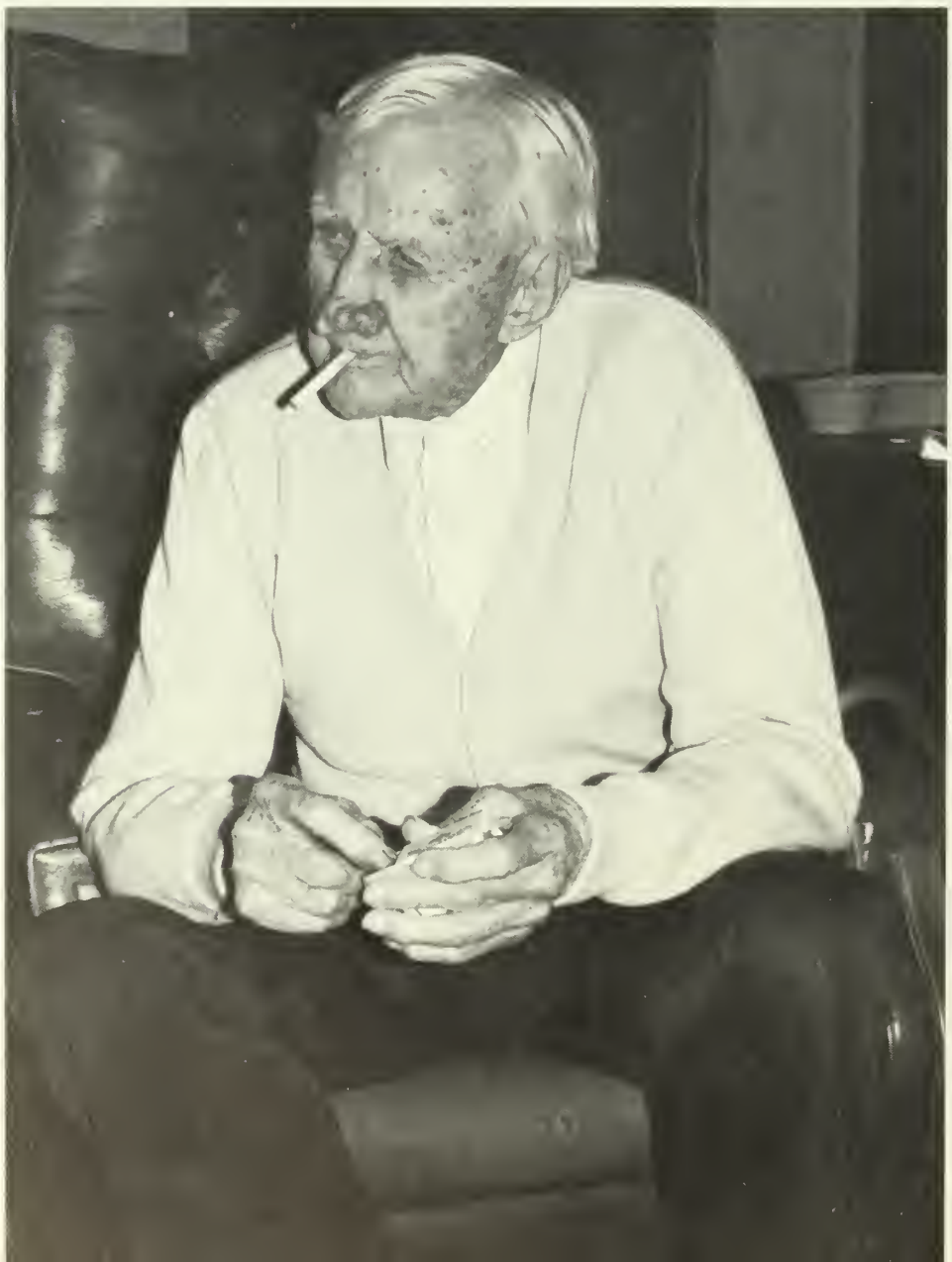
'A fine doctor and a hell of a fisherman'

Slowly opening a pack of "Lucky Strike" cigarettes Dr. Marcellus Giroud Whitlock leans back in his chair and pauses. A slight smile crosses the deeply creased face of the 96-year-old.

by Doug Vinson

The trim figure with a full head of white hair covering a still alert and keen mind says with mock earnestness "I probably would have lived to be an old man if I had stopped smoking these cigarettes."

Although he doesn't endorse the tobacco habit he started at age 15, Whitlock has seen enough birthdays come and go to make him the oldest living alumnus of MCG. He was graduated in 1910 and says, "If I could see



and hear better I'd still be practicing medicine today."

The spry physician officially retired from the practice he began in 1925 in the quiet, charming town of Trenton, S.C. when he was in his mid 80's.

His daughter, Mrs. Marguerite Stogner now lives with him and "keeps an eye on him."

Whitlock was born Oct. 14, 1884 in his parent's home in Edgefield County, S.C. Growing up in a family of 11 children on a large farm kept him busy during his younger years.

He attended school in a one-room school in Edgefield County before he entered the Medical College in 1906. He received his MD along with 14 other students in 1910.

"It cost me $1,700 for my four years of education in Augusta. When I interned at the old City Hospital in Augusta a patient paid $3 a day for a room. I was graduated with one of the smallest classes they ever had at the Medical College and they had us doing a little bit of everything."

Whitlock's family boasts several long-lived folks. Two of his brothers, who were also doctors, lived into their 90's and his parents died when they were 86.

Whitlock practiced medicine for one year in Uvalda, Ga. with a Dr. Collins and then moved to Red Hill, S.C. in 1912 and then to Trenton.

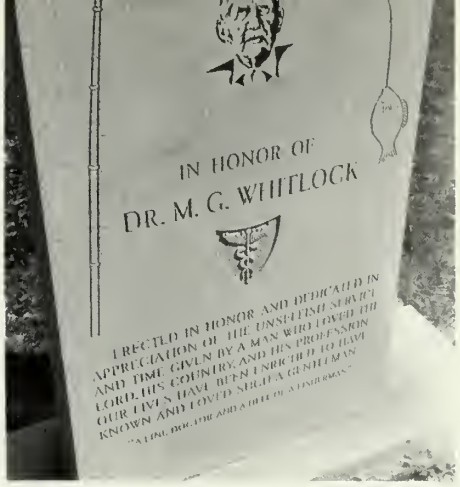
He says he made his first house calls astride a horse.

"Later I switched to a motorcycle," he says grinning. I don't think I could handle it too well now. In 1916 I bought a Ford car for $385.

"I did o.k. except the year the boll weevil hit the country. That was 1919 and I lost more than $1,000 in fees. Folks just couldn't pay."

Whitlock built his own office and served as his own secretary, office manager and nurse. He says the structure was just a small, simple building on the front lawn of his home. For privacy he would simply draw the shade until he was ready for his next patient. Then he would raise the shade when he was through indicating he was ready for another customer.

"Life was much simpler back then. Sometimes all a patient needed was an old-time remedy for a cough. We didn't get news of everything happening around the world as frequently and as in much as detail, so we weren't aware of everything happening everywhere."



A monument, erected by friends of the physician pays tribute to Dr. Whitlock's dedication in serving his fellow man and his accomplishments as an angler.

Whitlock's acumen as a diagnostician was widely respected by physicians in the surrounding area. The late Dr. Will Mulherin, a pediatrician, once said in the long years he had been closely associated with Dr. Whitlock he had never known him to make a mistake in diagnosing an illness.

"We didn't have much equipment back in those days. X-rays were just coming into use and there was a limited number of medicines to chose from. You had to be a good diagnostician and you had to treat things symptomatically."

Whitlock remembers two particularly severe flu epidemics, when he went from house to house with no time to rest between visits. "In one day I saw 68 people in that many separate visits. I was exhausted when I finally got a chance to stop.

"There was no Medicaid or Social Security at that time. Some people I never did charge. We never thought about getting government aid. All we had to fall back on was the poor house."

The town of Trenton honored Whitlock last summer on July 17 when everyone turned-out to celebrate "Dr. Marcelles Whitlock Day."

Gene Huit, who runs a grocery store in Trenton, was the driving force behind the funds collected from townspeople and friends to erect a monument honoring Whitlock on his special day.

Several speakers, including U.S. Rep. Butler Derrick praised Dr. Whitlock for his contributions to the community.

A monument bearing the following inscriptions was placed in the school yard directly across the street from his home.

"Erected in honor and dedicated in appreciation of the unselfish service and time given by a man who loved the Lord, his country, and his profession.

Our lives have been enriched to have known and loved such a gentleman."

Almost appearing as an after thought at the bottom of the monument is this sentence which indicates another area where Whitlock has applied his skills. "A fine doctor and a hell of a fisherman."

It seems that Whitlock has attained a lasting reputation as an angler as well as a physician.

Trenton has given him special permission to fish in any pond in the area. Although he can barely see, Mrs. Stogner takes him fishing and occasionally assists him in landing his catches.

Mrs. Clarice Wise, who moved to Trenton the same year Whitlock did and has known him all her life paid the following tribute to him when the monument was unveiled.

"Like another great physician, Dr. Whitlock looked out on a multitude of sick and needy people and he too was moved with compassion. For all the years he charged $1 for an office visit and $3 for a visit to a home night or day, he never failed to come when called. One dear lady visiting from Greenville became an office patient once and remarked that he would never get on Park Avenue at that rate as she handed him $5. He gave the $4 back saying he had no desire to go to Park Avenue."

Horsing around

Phillips' pace is a rapid step-by-step

by Julie Guillebeau

Some might call them "work-a-holics," but "super work-a-holics" more correctly describes Curtis and Barbara Phillips of Jacksonville, Fla.

Dr. Phillips, a 1943 MCG graduate has an active surgery/oncology practice and Mrs. Phillips heads up Step by Step, Inc., a thoroughbred race horse farm.

The Phillips don't race horses, rather they raise them, very carefully selecting brood mares and sires, hoping to breed potential winners. "It's really too speculative to race them," says Barbara. In addition to the race hopefuls, they also have hunters, which Barbara rides and shows.

But breeding and raising winners isn't all that easy, particularly when you do the work yourself. Barbara has donned jeans, boots and riding chaps and most any day you'll find her taking care of her "babies." In fact it takes so much time and effort, that the Phillips have moved into the barn, until they decide whether or not to build at the farm. She recently hired two young people to help her, which is particularly nice at the shows. Previously she traveled to the shows by herself, hauling her own horse van preparing the horses for the ring, including the very time consuming braiding of manes and tails . . . coming home literally bone-tired but with a handful of ribbons. "You learn to always be slightly uncomfortable, and very accustomed to the rain and mud at horse shows."

Two years ago, Barbara's major con-

cerns were modeling and civic and social activities, including being twice named to the "Best Dressed" list. Yes she still wears designer clothes and is involved in Jacksonville's society . . . but now only after the horses' comfort is assured.

The Phillips seem to thrive on work. Dr. Phillips begins Monday morning with office visits; Monday afternoon he's in the operating room at Baptist Memorial Hospital. Tuesday and Thursday he sees patients in his office all day. Wednesday, it's all day in OR, and Friday it's half and half. Beginning at 7:45 Friday mornings he does breast augmentations in his office, one an hour in fact until noon when he moves over to Baptist for more surgery.

A seasoned OR nurse once described Phillips' pace to a new nurse as "It'll be like hell, but it'll last for only a short while."

Phillips admits that he's a demanding, fast-paced surgeon, saying that he learned from one of the best — Dr. Edgar Pund. (Dr. Pund was chairman of pathology from 1932 to 1953; and then served as president until 1958.)

Phillips first studied pathology. A microscope sits predominantly on his desk even today. In fact he spent five years working with Dr. Pund. "I believe he did tolerate me longer than any other student." Phillips also studied surgery in Augusta and later was a surgical fellow at Memorial Sloan Kettering Cancer Center in New York City. In fact he was the only one to have been both a pathologist and surgeon prior to his taking training at Memorial Sloan Kettering.

He attributes his expertise in both pathology and surgery as special talents which have enabled to make innovative contributions to his profession.

Curtis Phillips was the first to use omental pedicled or fascia lata graphs in reconstructive surgery after radical mastectomies. He first used fascia to pad the implant in 1972, but didn't publish it until 1978 in *Breast*. And, then only at the insistence of nationally recognized breast cancer specialist, Dr. Jerry Urban.

As might be expected there's some resistance accepting his ideas. Phillips understands their concern and isn't pushing his work on anyone. Many of his patients are referred from other physicians and many from other patients. He agrees with many women who feel that even though surgery has saved their lives, they can ask for more, namely a prosthesis and a reconstructed breast.

He was invited to present a paper on his work at the San Antonio meeting of the Southern Medical Association, within the plastic surgery section. So, barriers are being broken. As one health care professional said, "Some don't think he should cross over into plastic surgery turf, but when the case is either a family member or one with complications, they call Curtis."

Phillips is willing to accept the belief that innovativeness is received with skepticism until standing the test of time. He recounts that "back in 1972 when I began doing some procedures in my office, tongues wagged, saying 'Curtis shouldn't do that', now it's not uncommon at all." In fact, Phillips is perfectly comfortable being a step ahead . . . "I like doing what others say is impossible."

He's also fully aware of other opinions. "People either like me or they don't," and he has their respect. In 1969, he was asked to assume the responsibilities of chairman of surgery at Baptist — a job that was supposed to last no more than five years. He served until 1977. He found it "lonely at the top" but others on the staff find that surprising. "Curtis Phillips is so strong he doesn't need help or pats on the back."

Phillips maintains an interest in the academics, being one of the few physicians in Jacksonville to have a resident assigned specifically to him for a three month rotation.

Phillips doesn't take time out for golf or tennis and weekends are as busy as weekdays — only the activity has moved to the farm.

Here surgeon turns farmer, helping Barbara in what many might consider manual labor unfitting to a surgeon's hands.

At the farm, Curtis tends a very large garden, clears land, builds fences, rides the tractor often and one of the horses some. As Barbara says, they're looking for a special horse for him.

Barbara herself is a newcomer to the horse world. "It's an after-30 venture." Daughter Kathy's now away at college, but Barbara is thoroughly immersed in the noble beasts.

Her drive to succeed has paid off — already she's qualified to ride in Madison Square Garden; and she has been invited to sell three of her yearlings at this spring's select Fasig-Tipton sale in Kentucky. No minor accomplishment since those invited to sell must meet stringent requirements on blood lines and pass onsight visits.

It's a bittersweet accomplishment for Barbara, for she's not looking forward to parting with yearlings. But she takes her business seriously. "We can't expect Curtis to be our oat-provider forever. A business must profit and we do that by selling the horses."

And a profit is expected. The yearlings all have impressive line, related to Bold Commander, Genuine Risk and other winners.

Barbara and Curtis agree that some friends question their sanity . . . then they visit the farm and see that work can quickly become pleasure.

Student aid losses causing concern among MCG students

By Cheryl Wilkes, Director of Student Financial Aid, MCG

Student assistance programs have become important in financing the increasing costs of education. This is particularly true for students at the Medical College of Georgia. Health curriculums are demanding and leave limited time for employment during the academic year. Approximately 50 percent of our students receive help from an educational loan program during their enrollment at MCG.

Over the past decade, students have been able to secure needed help through government student loan and scholarship programs. As the federal government seeks to achieve a balanced budget through reducing commitments, support for student assistance programs will be reduced. Federal funds formally going directly to schools to support student aid will be one area of reduction. At MCG, the loss is estimated to be $200,000 for 1981-82.

Another area targeted for reform is the Guaranteed Student Loan. Under this program, a student may borrow from any lender participating in the program. At this time, few restrictions exist on eligibility for the loan. The program will be modified to incorporate a determination of need based on family income and assets. According to the plan, the student will also be required to pay interest on the loan from the time the loan is incurred. Currently, the interest is paid by the federal government on behalf of the student while in school. The changes proposed are reasonable and will result in significant savings for the federal government. However, uncertainty exists as to the amount of time required to implement the changes and the continued willingness of lenders to make loans under the revised terms.

The lack of continuity in federal programs has been an on-going problem which has been compounded by the federal budget dilemma. New and innovative approaches to student financing mechanisms are needed for the decade of the 1980's and beyond. Increasing part-time employment opportunities for students is one avenue being pursued. Alumni support for a revolving student loan fund is needed; as borrowers repay outstanding loans, the repayments fund new loans to students. A gift can thus continue to work to support student enrollment in perpetuity. Memorial contributions are solicited.

Another innovative approach is currently under consideration by the Illinois legislature. Legislation would create an independent state student loan fund to complement the existing guaranteed student loan. Capital would be raised through a bond issue offered by an independent authority. The fund would be self-supporting with no cost to the state or liability. The bond rate would permit loans to students at reasonable interest in the vicinity of nine percent. (Student loan programs which rely on commercial capital carry interest rates in excess of eighteen percent.)

Georgia currently has a State Student Finance Authority which is empowered to issue revenue bonds to capitalize a sudent loan program. The General Assembly has seen fit to have the law should the need arise to obtain capital in this manner. Many states, including South Carolina, North Carolina, and Virginia, have chosen to finance the guaranteed student loan programs in those states through bonds. Dr. Don Payton, executive director of the State Student Finance Authority, has under investigation the potential for implementation of the bond concept within and without of the context of the Guaranteed Student Loan Program. Dr. Payton expressed interest in the Illinois model for an independent, self-supporting state fund to complement and supplement the federal Guaranteed Student Loan Program. The feasibility and need for such an educational fund will be carefully studied.

Students are integral to the future of the Medical College of Georgia. It is essential that financing mechanisms exist to permit MCG to attract the most qualified students and to assure that students may continue their education to graduation. The development of adequate loan funds is in the best long-range interest of our students, our institution and our state.

HOMECOMING

Homecoming 1981 was activity filled for visiting alumni and friends of the Medical College. The Jimmy Dorsey Orchestra, led by Lee Castle, entertained Thursday evening following a reception and dinner. There were many class reunions, continuing education courses, school alumni meetings, and numerous receptions and programs honoring special individuals during the three day event. May 14-16. The traditional Sophomore Parade, Stunt Night, and a "Rat Race" for joggers were held as alumni enjoyed meeting not only old friends and classmates but students, faculty and staff of MCG.

If you missed it all . . . mark your calendar now for May 6-7, 1982 and join the growing group of alumni who are renewing their acquaintance with the state's health sciences university.

Class Reunions

1930

1941

1931

1951

1936

1961

1966

1971

1976

SCHOOL OF DENTISTRY

Gordon T. Austin, '76, has been promoted to the rank of lt. cmdr. while serving at the Naval Regional Medical Center in San Diego, Calif.

SCHOOL OF MEDICINE

Robert G. Ellison, '43, MCG Charbonnier professor of surgery, is currently chairman of the American Board of Thoracic Surgery.

Kenneth H. Hyatt, '54, has been elected to fellowship in the American College of Physicians. Dr. Hyatt has been a resident of Norfolk for four years and is on the staff of Eastern Virginia Medical School.

LaMar S. McGinnis Jr., '54, has been appointed to the Commission on Cancer of the American College of Surgeons. Dr. McGinnis is currently chairman of the board of the Georgia Division of the American Cancer Society and secretary of the Georgia Chapter of the American College of Surgeons.

David W. Fillingim, '61, has been elected to serve as chief of staff of Savannah's St. Joseph's Hospital. Dr. Fillingim and his wife, Beverly, have two sons who attend Mercer University.

Thomas B. Merritt, '64, a retired USN medical officer, returned to Americus last year to join the staff of the Americus and Sumter County Hospital with a practice in psychiatry.

R. Mark Wilkiemeyer, '66, an Atlanta urologist, recently completed the microsurgery course for vasectomy reversal at the Johns Hopkins School of Medicine in Baltimore.

Paul E. Stanton Jr., '69, presented a lecture entitled "Hemodynamic Significance of the Kinked Internal Carotid Artery," at the Southern Association of Vascular Surgery meeting in San Juan, Puerto Rico. Dr. Stanton is presently director of surgery at the Georgia Baptist Medical Center in Atlanta.

Florence W. Winship, '71, completed a family practice residency at MCG. Dr. Winship and her husband, John, have moved to the Athens area where she is working in the University of Georgia Student Health Center.

Richard R. Reynolds, '73, has completed graduate training in thoracic and cardiovascular surgery at the Mayo Graduate School of Medicine. Dr. Reynolds plans to enter the private practice of cardiac surgery in Richmond, Va.

Donald J. Digby, '76, is currently serving as chief of ophthalmology at the Naval Regional Medical Center in Guam. He and his wife, Mary, have two children, Katie, 4, and Joey, 1.

SCHOOL OF NURSING

Jewel Lynch, '67, director of hospital education at Augusta's University Hospital, held a workshop on "Managing Burn-Out: The Organization's Dilemma," at Augusta College. She is president of the Augusta chapter of the American Society of Training and Development, a member of the American Association of University Women, and of the American Society for Health Manpower Educational Training.

Jacqualine Reade Mulanax, '74, has completed requirements for a master of arts degree in counseling in Zweibrucken, Germany. She has been a student in the Ball State University/USAF-sponsored graduate program offered at European military bases.

Linda Jo Dees, '74, is a nurse coordinator of the ob-gyn clinic at Vanderbilt University, Nashville, Tenn. She and her husband, Rob, have six children: Robby, Cheri, Paul, Richie, Erin, and Heidi Noelle.

Kathleen Kelly Sullivan, '75, lives in Steamboat Springs, Col., and is working as EMS Administrator for Routt County. She is the granddaughter of former President and Dean of MCG, **Dr. G. Lombard Kelly,** and daughter of **Dr. and Mrs. Daniel B. Sullivan.**

Linda Tilby, '75, has been named assistant administrator of patient services at St. Joseph Hospital in Augusta. She was also director of staff development at the hospital.

G. D. (Jay) Woldt, '77, recently received his MSN in nursing administration at the University of Oregon Health Sciences Center, Portland. Maj. Woldt is presently head nurse in the anesthesia section of the Landstuhl Army Regional Medical Center, Germany.

SCHOOL OF ALLIED HEALTH SCIENCES

Margaret Karen Smith, PT, '75, has established a practice in Eastman for the first time in the history of that Georgia city. She is also working with patients at Dodge County Hospital.

DEATHS

Tofey G. Smaha '28, Griffin
John R. S. Mays '30, Macon
James W. Watkins Jr. '48, Stone Mountain
James E. Cantrell '51, Atlanta
Jack B. Edwards Jr. '57, Cornelia

Medical College of Georgia
Division of Institutional Relations
Augusta, Georgia 30912

Second Class
Postage Paid at
Augusta, Georgia